Non-Medicaid Case Management
Intake Form

☐ **CSHCN** ☐ **Title V** ☐ **Other_____**

Date of referral:

Client Last Name:	Client First Name and Middle Initial:	Client/Case Number:
Part 1----Client Demographics		
Client Date of Birth:	SSN: - -	☐ Male ☐ Female
Parent/Guardian:	Home Phone: ( ) - Work/Alternate Phone: ( ) -	
Street Address:	City/Zip:	County:
Directions to home:		
Mailing Address:	City/Zip:	
Language Preference:	Interpreter needed: ☐ Yes ☐ No	
Primary Physician:	Phone number: Address:	
Referral Source:	Phone number: Address:	
Part 2----Health Condition/Health Risk or Psychosocial Risk/Condition (pregnant women only) use specific condition, risk or symptoms that describe the health condition if diagnosis is not confirmed		
Primary:		
Secondary:		
Part 3----Need for case management		
Reason for referral/need for case management:		

Client Last Name:	Client First Name and Middle Initial:	Client/Case Number:

Part 4----Client Choice

Has client/parent/guardian been informed of choice of case management providers?			☐ Yes ☐ No
Is client receiving case management services from another agency?			☐ Yes ☐ No
Name of other case management provider		Phone number of other case management provider	**( ) -**
If client is not to be enrolled, provide reason:	☐ Client does not desire/does not need case management services ☐ Currently receiving case management services from another provider ☐ Requires Medical Transportation service only ☐ Other _____		
If Client Not Enrolled for Services, Alternative Referrals Provided:			

Case manager signature Date

Case manager name (please print) Case management provider name